Updated Overview of Prospective Outpatient Hospital Payment Methodology

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Overview

- Recap of Timeline/Proposed Timeline
- Recap of Methodology
- Hospital Feedback
- Changes to Methodology
- Data Updates
- Examples of How Procedures Will Be Priced (separate handout)

Recap Timeline

- Feb/March ‘04– AHCCCS draft proposed rates
- March/April – Individual hospital meetings
- May – Senate Bill 1410 passes
- July 1 – “Interim methodology” implemented
- October 1 – CCR updates as mandated
- April – October ’04 – AHCCCS updates draft rates

Proposed Timeline

- October 2004 – Review updated rates
- Nov/Dec – Individual hospital meetings
- Jan/Feb – Finalize rates
- July 1, 2005 – Implement new rates

Recap of Methodology

- AHCCCS developed an outpatient hospital fee schedule with major features similar to the Medicare:
  - Grouping procedures into Ambulatory Payment Classifications (APCs) for ratesetting purposes
  - Grouping items that bundle with surgery and ED claims for pricing purposes

Recap of Methodology

- Data used to set fees was Arizona hospital-specific Medicare Cost Report and claim/encounter data.
- Each AZ cost-based fee derived was compared to the comparable Medicare fee and AHCCCS non-hospital capped fee schedule.
- If there was not sufficient cost data from AZ hospitals for a given procedure (that is, less than 20 observations statewide), then the Medicare fee for the procedure was used.

Recap of Methodology

Steps:

1. Define the dataset used to set the fees on.
   - Claims/encounters matching cost report years
2. Define the hospitals included in this dataset.
   - All non-IHS hospitals that had a cost report and AHCCCS outpatient hospital utilization.
3. Cost out the charges using revenue code CCRs.
   - Cost and charge data from Medicare Cost Reports
4. Inflate costed claims to midpoint of rate year.

Recap of Methodology

5. Bundle details with surgery and ED procedures.
   - Using the list of revenue codes from Medicare 2004 rule
6. Group procedures into APCs where applicable.
   - Using grouping methodology from Medicare 2004 rule
7. Calculate median cost at procedure code level (for laboratory) or APC level (all others).
8. Multiply each median cost by 105%.
9. Compare fee in Step #8 against comparable fee in Medicare. Select the higher of the two.
   - The "greater of" logic has been capped (see slide #9)

Hospital Feedback

- Proposed rates do not pay same as current CCR methodology.
- Proposed rates not provided for specific procedures (chemotherapy, radiation therapy, cardiology, PT, OT, ST, audiology, etc.)
- Proposed emergency room rates did not cover costs for high end trauma cases.

Changes to Fee Schedule

Changes to the fee schedule were based on:

- Hospital feedback
- CMS approval concerns
- Updated to reflect more recent data

Methodology Changes

Multiple Surgery Payment

- For claims with multiple surgeries, AHCCCS will pay the 1st surgery at 100% of the set fee, and the the 2nd surgery at 50% of the set fee (similar to Medicare). (Note: there are exceptions for those procedures that are intended to be paid 100/100).

Methodology Changes

- The “greater of” AZ hospital cost-based fee or Medicare fee may be capped when the Medicare fee is higher:
  - If the Medicare fee is higher, the Medicare fee will be used as long as the Medicare fee is not greater than 125% of the comparable AZ hospital-based fee. When the Medicare fee is more than 125% higher, the capped fee will be equal to the AZ hospital cost-based fee * 125%.
  - If the AZ hospital cost-based fee is higher, this cap will not apply.

Methodology Changes

- Peer groups and rate adjustments:
  - Large rural (100+ beds): Peer group adjuster = 20%
  - Small rural (0-99 beds): Peer group adjuster = 30%
  - Critical access hospitals: Peer group adjuster = 40%
  - Public: Peer group adjuster = 20%
  - Freestanding Children's: Peer group adjuster = 20%
  - Level I Trauma centers: Peer group adjuster of 20% applied to Level 2 and Level 3 ED claims only

Data Updates

- Updated fee schedule is based on FYE 2002 Medicare Cost Report data; March-based draft fee schedule was based on FYE 2001 data.
- Obtained more recent/more complete FFY2003 claim/encounter data from the system.
- FFY 2003 dataset includes more complete representation of all claims/encounters, including those with charges >$40,000, and multiple day claims, neither of which were priced, but defaulted to the statewide CCR in March.

Data Updates

- Many procedures (primarily alpha codes) were assigned rates based on the AHCCCS Physician Fee Schedule effective 5/1/04 (these procedures defaulted to statewide CCR in March-based draft fee schedule).

- Statewide default CCR based on FYE 2002 Medicare Cost Report data is .2957 (vs. .3175 using FYE 2001 data). AHCCCS still estimates that approx. 2-3% of total outpatient charges will be paid based on the statewide default CCR.

Data Updates

- The most prevalent procedures (based on charge volume) that appear in the dataset that are paid using the statewide default CCR include:
  - 33249 36000 36200 36245 36246 36489 36533
  - 36535 36600 51600 51701 51702 53670 59050
  - 61793 62290 69990 76001 76003 76005 76085
  - 78890 94665 94760 94761 94762 97601 99234
  - A4641 A4646 A4647 J2000
  - These procedures are estimated to comprise 2/3 of the total charges in the 2-3% estimated to be paid CCR.

How Procedures Will Be Priced

- See specific examples on separate handout